NEW YORK STATE | Department of Health

MLTC Partial Capitation Model Contract

Summary of Changes for term 1/1/17 – 12/31/21

January 2020

Introduction

- Summary of pertinent changes included in the 2017-2021 MLTC Partial Capitation Model Contract
  - Not an exhaustive analysis of changes
  - Proposed changes to the contract were discussed with MCO associations in November 2017 and again in March 2018
  - Final comparison of all changes after CMS review and approval was sent to MCOs in September 2019
  - Separate guidance will be issued by the Department to inform MCOs of the Department's expectations regarding policies, handbooks, or other documentation to meet new requirements
- Questions can be sent to MLTCinfo@health.ny.gov

Contract Term

- Term of this model contract is January 1, 2017 through and including December 31, 2021
- DOH expects MLTC plans to comply with any new requirements that arise from applicable federal and state statutes and regulations as of the effective date of the applicable law
- DOH expects MLTC plans to comply with any new requirements that are included in written guidance issued by the Department as of the effective date indicated in the guidance
- DOH expects MLTC plans to comply with any other new requirements as of the date of contract execution

Article I: Contract Term, Renewal and Termination

NEW Section F: Requirements Pertaining to Service Area Reductions and Mergers, Acquisitions and Other Arrangements

- Clarifies that requests to reduce a service area, or to alter or cease operations due to merger, acquisition or similar arrangement must be submitted in writing and receive DOH approval
- Consistent with MLTC Policy 17.02 (MLTC Plan Transition Process – MLTC Market Alteration) issued September 22, 2017

- Modifications to Article I, Section G also made to align with MLTC Policy 17.02

Article II: Statutory and Regulatory Compliance

NEW section E: implementation of a compliance plan in accordance with requirements of 42 CFR § 438.608, N.Y. Social Services Law § 363-d, and 18 NYCRR Part 521.

- 42 CFR § 438.608 contains MCO and subcontractor responsibilities for program integrity
- N.Y. Soc. Serv. Law § 363-d requires medical assistance providers to adopt effective compliance program elements and implement an appropriate compliance program
- 18 NYCRR Part 521 establishes standards for provider compliance programs that must be met in order to submit claims for Medicaid payments or be eligible to receive Medicaid payments

Article III: Contractor Services Area and Age Groups Served

- Section A modifies provision regarding reduction in service area to achieve consistency with MLTC Policy 17.02.

- Section A also adds a new paragraph regarding the procedure for expansion of a service area.

- New obligations to notify affected enrollees of service area modifications or change in age groups served

Article IV: Eligibility for Partial Capitation Managed Long Term Care

- NEW Section E describes the initial eligibility determination process for MLTC enrollment made by the Conflict Fee Evaluation and Enrollment Center (CFEEC)
    - All applicants seeking enrollment to be forwarded to CFEEC in accordance with MLTC Policy effective October 1, 2014
    - Disagreement with the CFEEC determination should be first brought to CFEEC for clarification, then if not satisfactorily resolved referred to DOH

Article V: Obligations of the Contractor

- NEW Section A.4.a: a sufficient and adequate network for the delivery of all covered services includes demonstrating that an MLTC plan's network contains sufficient Indian Health Care Providers to ensure access to native American enrollees. 42 CFR 438.14(b)

- NEW Section A.7: long term services and supports must be delivered in settings consistent with 42 CFR § 441.301(c)(4).
  - Information about the CMS Home & Community-Based Services (HCBS) Final Rule can be found here: https://www.health.ny.gov/health_care/medicaid/redesign/home_community_based_settings.htm

Article V: Obligations of the Contractor

- Section B.1.c.ii adds language requiring that a Person Centered Service Plan (PCSP) be developed based on the plan's initial assessment conducted on a new enrollee.
- PCSP references are added throughout the contract and are consistent with guidelines
  - Person Centered Service Planning Guidelines for Managed Care Organizations were issued by the Department December 19, 2018: https://www.health.ny.gov/health_care/medicaid/redesign/cfco/2018-12-19_pcsp_guidelines.htm
- Section B has some new requirements with respect to potential enrollees:
  - MLTC plan must provide the applicant with written notice of the proposed PCSP prior to enrollment
  - MLTC plan must provide a monthly report listing all individuals for whom an assessment was completed, within 10 business days of the close of each month.

Article V: Obligations of the Contractor

- Section C.9 adds the requirement that an enrollee being disenrolled from another plan for certain reasons be provided with continuity of services for 120 days, or until the new plan has conducted an assessment and the enrollee has agreed to the new PCSP.

- This captures the obligation as set forth in MLTC Policy 17.02 (MLTC Plan Transition Process – MLTC Market Alteration) issued September 22, 2017

- Section D contains minor clarifications regarding the disenrollment process, including clarification of the existing obligation to disenroll enrollees who do not require or receive at least one community based long term care service per month.

Article V: Obligations of the Contractor

- NEW requirement in Section E.4 that MCOs retain in each enrollee record documentation that the enrollee received the information and notifications about enrollee rights that are required by Appendix L.
    - The information and notifications in Appendix L are not new and were not substantively changed.

- NEW requirement in Section E.7 that the MCO must provide at least 30 days advance written notice of a benefit package change to enrollees.

- NEW language in Section E.8 and 9 regarding disenrollment without cause when the Department determines that the MCO has repeatedly failed to meet its obligations.

Article V: Obligations of the Contractor

- Section F (Quality Assurance and Performance Improvement Program) adds a new section allowing MCOs to offer incentives to enrollees for completing a health goal or to promote the delivery of preventive care services
  - Materials must be submitted to the Department for review and approval at least 60 days prior to the proposed commencement of the program

- Section G updates language regarding marketing activities
  - MLTC Partial Capitation Marketing Guidance issued June 21, 2017 has not changed.

Article V: Obligations of the Contractor

- Other NEW provisions to Section G:
  - MCOs may not list contact information related to those who perform eligibility assessments in enrollee materials
  - CFEEC contact information must be on all materials to potential enrollees
  - Approved versions of outreach or informational materials that are translated into languages other than English do not need to be resubmitted to the Department for approval, but MCO must keep Certificate of Accuracy on file

Article V: Obligations of the Contractor

- Section J (Person Centered Service Planning and Care Management) clarifies that MCOs may subcontract care management services by entering into a Care Management Administrative Services (CMAS) agreement
  - Guidelines can be found in MLTC Policy 13.17 REVISED (issued October 18, 2013): https://www.health.ny.gov/health_care/medicaid/redesign/mltc_policy_13-17_rev.htm

- Clarification that minimum care management requirement is for one successful care management telephone communication per month and if no successful communication the reason thereof must be documented in the care management record

Article V: Obligations of the Contractor

- Clarification of care management obligations for enrollees that have long term placement in a nursing home:
  - MCOs are generally exempt from care management for such enrollees
  - However, MCOs must provide appropriate care management to enrollees who expressly register intent to return to the community
  - All nursing home enrollees must continue to receive UAS assessments

- Consumer Directed Personal Assistance Services (CDPAS): MCO must notify eligible enrollees at initial assessment and at reassessment that CDPAS is an available voluntary benefit, and must document such notifications in the enrollee's record

Article V: Obligations of the Contractor

- Section M: Advance Directives
  - MCOs continue to be required to maintain policies and procedures regarding Advance Directives
  - MCOs must inform each enrollee at the time of enrollment of his or her rights to formulate Advance Directives

- NEW Section T: Elections Based on Moral or Religious Grounds
  - Sets forth requirements to be met before an MCO may elect not to provide coverage of a counseling or referral service because of an election based on moral or religious grounds
    - Notice to enrollees at least 30 days prior to policy
    - Notice to the department with MLTC application or upon adoption of the policy

Article V: Obligations of the Contractor

- NEW Section U: Emergency Preparedness
  - Requirement for an Emergency Preparedness Plan (EPP) is consistent with guidance sent to MLTC plans by the Department on May 3, 2016 regarding emergency preparedness

- NEW Section V: Discharge Planning
  - Requires MCOs to use reasonable efforts to work with providers in developing discharge plans for enrollees when a change in the level of care is proposed
  - Clarifies that MCOs must continue to cover stay in a residential health care facility when a safe discharge cannot be arranged solely due to the enrollee's lack of housing

Article V: Obligations of the Contractor

- NEW Section W: MCO may provide cost-effective alternative services or settings, as permitted by 42 CFR 438.3(e) and approved by the State

- NEW Section X: Requirements for the Money Follows the Person (MFP) Demonstration
  - Enrollment Agreement must include MFP Attestation
  - Member Handbook must describe MFP

Article V: Obligations of the Contractor

- NEW Section Y: Program Integrity Responsibilities
  - Compliance with state and federal program integrity requirements
  - MCOs must have a compliance program, including a compliance officer and a regulatory compliance committee on the board of directors
  - Return of overpayments within 60 days of identification
  - MCOs with enrolled population of 10,000 or more in the aggregate in any year must comply with 10 NYCRR 98-1.21, including development of a fraud and abuse prevention plan and a Special Investigations Unit (SIU)
  - MCOs with an enrolled population of fewer than 10,000 required to annually submit a report of overpayments recovered
  - MCOs must withhold payments to providers within 5 business days of being directed by the Department or OMIG to do so

Article V: Obligations of the Contractor

- Program Integrity (continued):
  - Where MCO refers a potential case of fraud or abuse to OMIG, MCO may be eligible to share in the portion of the non-federal share of recovery made by OMIG
  - OMIG determines percentage, based on extent to which MCO contributed to investigation and recovery
  - Percentage not less than 1% or greater than 10% of non-federal share
  - MCOs subject to liquidated damages from the Department or OMIG for failure to report, or inaccurately reporting, monies recovered
  - MCOs must have written policies providing information about False Claims Act and other applicable laws, including whistleblower protections
  - Potential cases of fraud, waste and abuse must be reported to Department and OMIG, and optionally to Office of the Attorney General (MFCU)

Article VI: Payment

- NEW language in Section C (Rate-Setting Methodology): in prospectively determining capitation rates, no payments to providers located outside of the United States will be considered

- Section F (Department Right to Recover Premiums and Contractor Duty to Repay) has been updated with more specificity around the scenarios under which capitation amounts can be recovered

- Section L (Notification Requirements to LDSS Regarding Enrollees) modified to change the time frame for notification to LDSS of an enrollee's admission to a nursing facility from prior to the admission to within 5 business days of the information becoming known to the MCO

Article VII: Contractor Relationship with Providers

- Section 4 clarifies that Participating Providers may list their MCO affiliations, but may not steer their patients to a particular MCO or managed care product type
  - Providers must direct patients to the enrollment broker (NYMC/Maximus) for education on plan options
  - Providers may not display an MLTC plan's outreach materials

- Section 13 replaces the previous language regarding alternate payment arrangements with specific reference to the NYS Value Based Payment Roadmap and its targets
  - The VBP Roadmap is available in the VBP Library on the DOH website: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_reform.htm

Article VII: Contractor Relationship with Providers

- NEW: Section C.14 sets forth the appeals and grievance system information that an MLTC plan must share with Participating Providers and subcontractors upon entering into a contract

- NEW: Section C.15 reminds MLTC plans that punitive action may not be taken against providers who request expedited resolutions or support an enrollee's service authorization request, appeal, or grievance.

Article VII: Contractor Relationship with Providers

- NEW: MLTC plans must conduct annual reviews of appointment availability and access surveys
  - Corrective action must be taken with providers who fail to meet reasonable standards
  - Survey results to be kept on file and available for Department's review upon request
  - Pursuant to 42 CFR 438.206

Article VII: Contractor Relationship with Providers

- NEW: provisions regarding recovery of overpayments to providers
  - MLTC plans must have a mechanism in place for providers (both participating and non-participating) to report when they have received an overpayment
    - Providers must notify plan in writing of the reason for the overpayment and return the overpayment within 60 days of identification
  - If there is a final determination, OMIG or DOH may request that MLTC plan recover an overpayment, penalty or other damage from Participating Provider
    - OMIG or DOH may charge provider a collection fee to account for reasonable costs incurred to collect the debt
    - Collection fee may be retained by MLTC plan if the full amount owed to the Medicaid program is first collected

Article VII: Contractor Relationship with Providers

- NEW: provisions regarding recovery of overpayments to providers (cont'd)
  - MLTC plan may enter into an agreement with OMIG to conduct a combined audit or investigation of a plan's provider (both participating and non-participating) or subcontractor
  - Agreement must be executed prior to commencement of audit or investigation
  - Agreement will include the portion of recoveries (that is not owed to the federal government) to be shared

- MLTC plan may retain recoveries from a Participating Provider if not recovered pursuant to direction from DOH or OMIG, or pursuant to a combined audit or investigation

Article VII: Contractor Relationship with Providers

- NEW: Section M contractually requires MLTC plans to comply with minimum wage laws and develop protocols for compliance

- NEW: Section O contains information regarding on-menu and off-menu Value Based Payment (VBP) arrangements
  - Information is consistent with the VBP Roadmap and the Clinical Advisory Group (CAG) reports
  - VBP Roadmap and CAG Playbooks are available in the VBP Library on the DOH website: https://www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_reform.htm

Article VII: Contractor Relationship with Providers

- NEW: Section P – Native Americans
  - PCPs must coordinate services for Native American enrollees who choose to access primary care services through a tribal health center
  - Native American enrollees must be permitted to select a Participating Indian Health Care Provider (IHCP) to serve as PCP
  - MLTC plans must compensate IHCP (both participating and non-participating) for services provided to a Native American enrollee at:
    - Negotiated payment rate or
    - If no negotiated rate, not less than what plan would pay a non-IHCP Participating Provider for similar services
    - Whether participating or non-participating, never less than Medicaid FFS rate for similar services

Article VIII: Records Reporting and Certification Requirements

- Section F.3.b.i: requires MLTC plans to submit encounter data to the Department twice per month
  - Clarifies that encounter data should not be submitted more than 15 calendar days from the date or adjudication of the claim
    - MLTC plans must maintain documentation indicating the date of receipt of the claim from the provider
  - Any additional encounter data records after adjudication of the original claim should also not be submitted more than 15 calendar days from the date of adjudication
  - Valid provider identification number should be included

Article VIII: Records Reporting and Certification Requirements

- Fraud, waste and abuse reporting requirements in F.3.d were replaced for compliance with 42 CFR Part 438
  - All cases of potential fraud, waste and abuse to be reported by MLTC plan and its subcontractors to OMIG
    - In addition, MLTC plan or its subcontractors may also refer cases of potential fraud to the Office of the Attorney General (Medicaid Fraud Control Unit)
  - Time frame for submission to OMIG changed from 7 days to 5 business days
  - Timing for submission of Program Integrity Annual Assessment Report changed to between January 1 and January 31 each year (was previously by December 31 each year)

Article VIII: Records Reporting and Certification Requirements

- MLTC plans to submit updated provider network report through Provider Network Data System (PNDS) portal on a quarterly basis, or more frequently if network changes occur
  - Annual notarized attestation required that the providers listed in each submission have executed a participating provider agreement with MLTC plan

- Auto Assigned Population – Notice of Action Report was deleted
  - Identified instances where MLTC plan issued a notice of action involving a reduction of split shift or live in services, or reduction of hours by 25% or more

Article VIII: Records Reporting and Certification Requirements

- NEW: section F.3.s Provider Investigative Report
  - Quarterly report of all provider (both participating and non-participating) investigative and educational or re-educational activities
  - Submitted to DOH and OMIG

- NEW: section F.3.t Provider Overpayment Report
  - Reports all overpayments identified or recovered, specifying payments due to potential fraud
  - Reports all unsolicited refunds received from providers (both participating and non-participating)
  - Submitted “promptly” to DOH and OMIG
  - Pursuant to 42 CFR 438.608

Article VIII: Records Reporting and Certification Requirements

- NEW: section F.3.u Contractor Overpayment Report
  - Reports identification of, or receipt of notice of, capitation or other payments in excess of amounts specified in model contract
  - Submitted within 60 days of identification to DOH and OMIG
  - Pursuant to 42 CFR 438.608

- NEW: section F.3.v Provider Eligibility Report
  - Monthly report of any change in a Participating Provider's circumstances that may affect its eligibility to participate in the managed care program
  - Includes for cause terminations and non-renewals
  - Submitted to DOH and OMIG
  - Pursuant to 42 CFR 438.608

Article VIII: Records Reporting and Certification Requirements

- NEW: section F.3.2 Deficit Reduction Act Certification
  - Annual certification that MLTC plan has maintained the written policies, and any employee handbook, required by federal law; and that they have been adopted, published, and disseminated among employees, subcontractors and agents
  - Pursuant to section 1902(a)(68) of the Social Security Act
  - Submitted to OMIG in December of each year using a form provided by OMIG on its website

Article VIII: Records Reporting and Certification Requirements

- Section M modified to expand OMIG right to audit and impose penalties if audit determines that MLTC plan's filed report contained misstatements of fact within the reported costs and revenue that impacts the accuracy of the data used in the rate setting process
  - Sets forth methodology for calculation of penalty
  - Misstatement of fact to be reported as a prior period cost adjustment on next MMCOR
  - Gives examples of misstatements of fact

Article VIII: Records Reporting and Certification Requirements

- NEW Section Q: Notification to Audit
  - MLTC plan must notify OMIG of its intention to initiative an audit of a provider (applies to Participating Providers and Non-Participating Providers)
  - Notifications must include provider name, address, audit scope and time period to be reviewed
  - OMIG will respond within 10 business days: either no conflict with audit, or conflict exists and audit must stop
  - If no response within 10 business days, MLTC plan may proceed with its audit
  - OMIG will similarly notify MLTC plan of its intention to audit a provider, and plan has 10 business days to alert OMIG of a conflict
    - Once notified of OMIG's audit, plan must provide requested records and may not initiate an audit of same provider or enter into a settlement agreement or similar consideration with provider

Article X: General Requirements

- NEW: Section RR – Cultural and Linguistic Competence – required by Part 438
  - MLTC plan must promote and ensure services are delivered in a culturally competent manner
    - Includes limited English proficiency, diverse cultural and ethnic backgrounds, diverse sexual orientations, gender identities, faith communities
  - Provider network must be inclusive and culturally competent
  - Plan's internal quality assurance program must have a cultural competence component
  - Plan must facilitate annual training for its staff
  - Plan must require Participating Providers to annual certify it has completed State-approved training for its staff who have regular and substantial contact with enrollees

Article X: General Requirements

- NEW: Section TT – Physical Location
  - MLTC plan may not be located outside of United States
    - Includes District of Columbia, Puerto Rico, Virgin Islands, Guam, Northern Mariana Islands, American Samoa

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